

**American Indian  
Task Force Report  
on the Year 2000  
Health Promotion Objectives  
and  
Recommendations  
for California**

May 1992

Prepared by the American Indian Task Force for the  
Unity in Health, Diversity in Culture Conference, sponsored by the  
California Department of Health Services Health Promotion Section  
in June 1991.



**American Indian  
Task Force Report  
on the Year 2000  
Health Promotion Objectives  
and  
Recommendations  
for California**

May 1992

Prepared by the American Indian Task Force for the  
Unity in Health, Diversity in Culture Conference, sponsored by the  
California Department of Health Services Health Promotion Section  
in June 1991.

*The comments and recommendations expressed in this report are of the American Indian Task Force and do not necessarily reflect the activities or plans of the California Department of Health Services. All four reports were presented by the Multi-Ethnic Steering Committee for Health Promotion to the California Department of Health Services in May 1992 in Sacramento, California.*

This report has been printed with funds from the  
California Department of Health Services,  
Health Promotion Section.

For more information on any of the Multi-Ethnic Health Promotion Task Force Reports, please contact the California Department of Health Services Health Promotion Section, PO Box 942732, Sacramento, CA 94234-7320 916/322-6851

---

# Table of Contents

Forward	i
Acknowledgments	iii
Steering Committee	iv
Summary and Background for Advancing a Multi-Ethnic Health Promotion Agenda for California	
• The Multi-Ethnic Health Promotion Planning Model	1
• Recommendations for Intervention Strategies	7
• Future Directions	11
• References	12
Year 2000 Health Promotion Objectives and Recommendations for American Indians in California	
• Summary on the Preparation of the American Indian Task Force Report	15
• American Indian Task Force	18
• Priority Health Promotion Topics	
-- Cancer	21
-- Diabetes	27
-- Heart Disease and Stroke	31
-- Nutrition	37



# Forward

---

As a result of the astounding scientific and medical achievements of the 20th century, we now know that a fuller measure of health is within reach for all Californians. Yet, despite the overall achievements in health status, the burden of poor health all too often falls more heavily on some population groups than on others. The fact that this “gap” in health status occurs more frequently among people with low income and people belonging to racial/ethnic “minority” groups has been documented both nationally and in California. These groups are identified as African American, American Indian, Asian and Pacific Islander, and Hispanic/Latino. Rather than use the term “minority”, the Steering Committee decided that the term “multi-ethnic” was more appropriate given the growth of these populations in California. Not only does this gap in the health status experienced by these racial/ethnic groups include consistently higher excess mortality and poorer overall health as measured by infant mortality rates and disability levels, it also involves disparities in health-related information and resources as well.

Confronting the gap in health status among the State’s multi-ethnic groups began with a vision, followed by action, on the part of Lela Folkers, Barbara Marquez, Virginia Leung Jang, and other key staff of the California Department of Health Services’ Health Promotion Section, which sponsored and coordinated the first Multi-Ethnic Health Promotion Conference in June 1991. As an integral part of that conference, four Ethnic Task Forces, under the leadership of Steering Committee members, were formed to identify critical areas of need with regard to health promotion within their respective communities and then worked one step further to develop health promotion objectives and recommendations for each area. This information was then assembled in the form of a series of discussion papers, which together served as the centerpiece of the conference’s activities.

In addition to the information contained in the original discussion papers, the enclosed Ethnic Task Force Report now incorporates a wealth of additional information garnered from hundreds of conference participants and reviewers. The Task Force Report is prefaced by a summary and background which provides a description of the model used for the development of the ethnic-specific health promotion objectives, a summary of major recommendations, and a discussion of future directions and uses of the information.

The challenge of ensuring good health for all residents is of critical importance in California because our state is home to a large share of the nation’s total racial/ethnic populations. It is projected to be the first mainland state with a majority of “minorities,” an emerging majority if you will, possibly as early as the year 2005. California, as nowhere else in the United States, is a microcosm of multi-cultural living. Strategies to improve health must be based on the fullest possible knowledge of the influences on health and illness for a particular population group. But more often than not, strategies to improve the health of racial/ethnic groups are transplanted or adapted from interventions and research based on middle-income whites. Unfortunately, differences in culture, race, and language are all too often treated as a series of obstacles which must be overcome in providing health care services.



As a member of California's emerging majority, and on behalf of the Multi-Ethnic Health Promotion Conference Steering Committee and its four Ethnic Task Forces, we present the enclosed summary and information on ethnic-specific health promotion objectives and implementation strategies for the year 2000 for California. This report acknowledges the growing recognition by California's multi-ethnic communities of the importance of prevention and early detection of the major causes of excess mortality, illness, and disabilities rather than treatment of a disease after it has occurred. They also emphasize the overwhelming importance of cultural diversity as a guiding principle in the development of health promotion policies and practices.

As the product of one of the largest such undertakings ever brought to fruition in the United States, the Task Force Reports represent the product of many months of work by concerned individuals, health care providers, and educators from public health, academia, and most importantly, from the State's ethnic communities themselves. On behalf of all of us associated with the conference, I wish to take this opportunity to thank each Task Force member and conference participant for his/her contribution to this important effort. Continued cooperation and commitment from such groups and individuals across California will be needed if we are to move our multi-ethnic health promotion agenda forward.

Reaching the goal of equitable health status for all racial/ethnic groups will be one of the most important public health achievements of our time, not just for California, but for many other states as well. Good health and well-being is the greatest legacy we can leave our children and future generations. What we do now will influence the future for good or for bad. Therefore, I invite each of you to join in adapting and using the enclosed objectives and recommendations in your community.

Henry Montes, Chair  
Steering Committee  
Multi-Ethnic Health Promotion Conference

## **Acknowledgments**

The development of each Task Force Report involved literally hundreds of individuals and organizations. These reports would not have been possible without their commitment and many hours of volunteer work. A special thanks also to the major sponsors of the Multi-Ethnic Health Promotion Conference:

- The California Department of Health Services' Health Promotion Section
- U.S. Public Health Service's Centers for Disease Control (U58/CCU900590-07)
- The California Department Health Services' Tobacco Control Section
- Federal Indian Health Services, California Area Office

And a debt of gratitude to Kelly Haarmeyer and Pat Felten from the California Department of Health Services for their assistance in preparing each report for publication.

---

# **Steering Committee**

## **Multi-Ethnic Health Promotion Conference**

**Henry Montes, Chair**

Henry J. Kaiser Family Foundation

**Garth Collins**

San Francisco Department of Public Health

**Martha Diaz**

Hispanic Women's Health Association

**George Flores, MD**

Sonoma County Department of Public Health

**James Forde**

California Black Health Network

**Felicia Hodge, DrPH**

American Indian Graduate Program, University of California, Berkeley

**Mingyew Leung**

Asian American Health Forum, Inc.

**Lia Margolis**

Los Angeles County Department of Health Services

**Debra Oto-Kent**

Health Education Council

**Nampet Panichpant-M**

Orange County Health Department

**John Walmsley**

U.S. Public Health Service, Region IX

**David Whitehorse**

American Indian Program, San Diego State University

**Arica Williams**

Indian Health Services, U.S. Public Health Service

**Elaine Gaines Williams, PhD**

Charles Drew University of Medicine and Sciences

**Judy Makimoto Woo**

Asian Health Services

**Lela F. Folkers, Chief**

**Barbara Marquez, Coordinator**

**Virginia Leung Jang**

Health Promotion Section, California Department of Health Services



# **Summary and Background**

# Summary and Background for Advancing a Multi-Ethnic Health Promotion Agenda for California

## The Multi-Ethnic Health Promotion Planning Model

### Preliminary Planning Efforts

To better address the prevention and health promotion needs of the state's growing multi-ethnic groups, in 1987 the California Department of Health Services' (CDHS) Health Promotion Section coordinated and participated in a two-day workshop in Los Angeles. The purpose of the workshop was to identify emerging and critical issues germane to the state's ethnic groups. Participation was by invitation and the workgroups were largely comprised of representatives from the state's public health and social service organizations, voluntary health agencies, and academic institutions. Three major conclusions emerged from that workshop:

- There is a large unmet need for culturally appropriate and relevant health promotion and risk reduction services targeted toward the state's racial and ethnic population groups.
- There is a wealth of innovative community-based programs being undertaken throughout the state which have proven successful and which might serve as program models for other ethnic communities.
- There is currently no forum or structure for ongoing information exchange of innovations, successful strategies, and program models specifically for health promotion among multi-ethnic groups.

There were strong indications from workshop participants that the planning and direction for future "minority" health promotion efforts will be most successful if they originate from the racial and ethnic community. Since advocacy and information exchange were needed, the CDHS would play a critical role by: 1) directing funding and technical assistance to minority communities; 2) continuing to act as central focal point for data and technology transfer; and 3) creating forums for information exchange by the state's racial and ethnic minority groups. Since that time, the CDHS' Health Promotion Section incorporated most of the recommendations from the 1987 workshop into its state and local assistance programming. The consensus building model used for planning the first Multi-Ethnic Health Promotion Conference held in Sacramento in June 1991 represents one such collaborative effort on the part of many organizations, agencies, groups, and individuals to create the opportunity for communities to advance a multi-cultural health promotion agenda for California.

## **Planning Process**

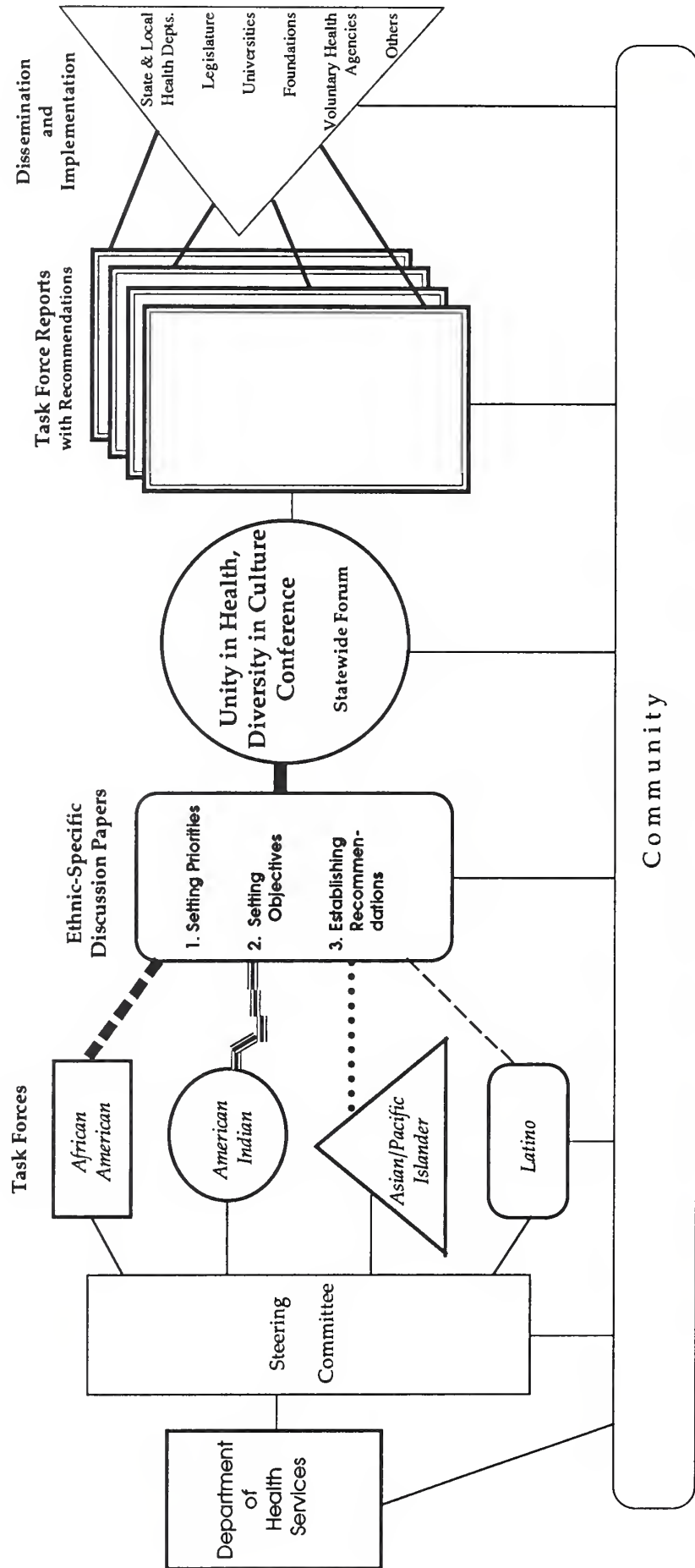
As depicted in Figure 1, “Model for the Development of California Ethnic-Specific Year 2000 Health Promotion/Disease Prevention Objectives,” the Multi-Ethnic Health Promotion Conference was part of a larger planning and consensus-building process. The major elements of the model included the CDHS, a steering committee, four ethnic task force groups, and the community. Working together towards the common goal of creating a multi-ethnic agenda, the task force groups took the lead in (1) identifying health promotion priorities for their respective communities; (2) setting objectives; and (3) developing recommendations for strategies to be pursued to improve health promotion for the state’s ethnic groups.

The methods employed by the task force groups to gain community involvement and to develop the initial discussion papers included: identifying key individuals and groups involved in service delivery, research, training or who otherwise have health promotion knowledge and experience; conducting community assessments through surveys or interviews; and reviewing existing data and key pieces of literature. Once the priority areas were selected and the discussion papers were developed, they were circulated for review and then presented during the conference. Finally, feedback from conference participants concerning priorities, objectives, and recommendations was consolidated into the final task force reports, which together serve as a framework for advancing a multi-ethnic health promotion agenda in California. As shown by the model, community involvement was a key ingredient at each juncture in the development of health promotion objectives, from the initial conceptualization of the project by the CDHS to the dissemination and implementation of the objectives by community groups. This latter activity is described in the “Future Directions” section.

Developing the California Multi-Ethnic Health Promotion Agenda was a one-year consensus-building project that involved a number of resources, key groups, and individuals. The Multi-Ethnic Health Promotion Agenda was conceptualized in response to and as an outcome of earlier planning and program implementation activities of the Health Promotion Section. To ensure that the new health promotion agenda reflected the needs of California’s increasingly diverse population, in November 1990 the CDHS’ Health Promotion Section organized, through internal and external nominations, a steering committee of 15 public health leaders who represented ethnic community-based organizations, academia, and federal and county governments. The steering committee, chaired by Mr. Henry Montes, provided overall guidance for the conference and its members were instrumental in forming and providing leadership for each of the ethnic task forces.

Convened in January 1991, the ethnic task forces were charged with setting health priorities, establishing objectives, and developing recommendations for four key ethnic groups: African Americans, American Indians, Asians and Pacific Islanders, and Latinos. Each group met separately over a six-month period and developed unique working arrangements in accordance with its own infrastructure, resources, and cultural norms. Continuity was provided by the members of the steering committee who provided leadership on the various task forces. The CDHS provided staff support and was able to reimburse the costs of some expenses. However, it should be noted that the majority of the necessary resources were supplied by the steering committee and the task force members on a voluntary basis.

Figure 1  
**Model for the Development of  
 California Ethnic-Specific Year 2000  
 Health Promotion/Disease Prevention Objectives**





The resource documents used in the task force deliberations were Healthy People 2000: National Health Promotion and Disease Prevention Objectives, published by the U.S. Department of Health and Human Services<sup>1</sup> and the Summary of Healthy People 2000, prepared by the American Public Health Association<sup>2</sup>. Due to the time constraints inherent in preparing for the June 1991 conference and the fact that the major topic of concern was health promotion and the prevention of chronic disease, the task force groups were asked to limit their deliberations to 10 of the 22 topic areas (see Table 1) listed in these two documents. Within these areas, task force groups were asked:

- To prioritize topic areas and provide a rationale statement concerning the importance, in terms of the health status of the ethnic population.
- To review and comment upon the relevance to the ethnic group of the Year 2000 health status, risk reduction, and service and protection objectives. Each task force was thus able to accept the objectives as written, modify the objectives to make them more relevant, or prepare completely new objectives.
- To make recommendations on three levels -- policy, community interventions, and resource development -- for achieving the objectives.

More than 100 task force members participated in the development of the initial discussion papers. As described more fully in each of the Task Force reports, during the months preceding the conference, each task force employed several activities for prioritizing topics, establishing objectives, and formulating recommendations. For example, some groups formed subcommittees and held regional meetings, while other groups conducted statewide surveys, examined available state and national data bases, and solicited written comments from knowledgeable reviewers.

### **The Conference Objectives, Process, and Participants**

The 1991 Multi-Ethnic Health Promotion Conference played a central role in the development of a multi-ethnic health promotion agenda. It provided a statewide forum to:

- Build public and private partnerships for resource development to expand and enhance health promotion programs and services for multi-ethnic communities.
- Identify and disseminate culturally appropriate and sensitive health promotion and chronic disease programs and models for the African American, American Indian, Asian/Pacific Islander, and Latino communities.
- Create a forum for participants to contribute to the development of a California Multi-Ethnic Health Promotion Agenda based upon the Year 2000 Objectives.
- Explore existing educational and community-based programs and surveillance and data systems and identify gaps in these systems related to multi-ethnic communities and their health status.

In June 1991, the discussion papers were debated at the statewide conference referred to as the Multi-Ethnic Health Promotion Conference, but officially titled “Unity in Health, Diversity in Culture, Advancing a Multi-Ethnic Health Promotion Agenda for California.” Although an attendance of approximately 150 conference participants was initially expected, pre-conference registration had to be closed once the number of participants reached 550 people.

The first day of the conference was reserved for discussion groups on data and surveillance systems, and for seminars on chronic diseases and risk factors, including those related to unintentional injuries and violent and abusive behavior. On the morning of the second day, conference participants were able to attend workshops to learn first hand about successful community interventions, policy strategies, and ways to develop resources. The ethnic-specific breakout sessions were held the remainder of the day. During the breakout sessions, participants had an opportunity to discuss and comment upon the papers they had received earlier as part of the conference materials.

Each breakout session had a facilitator and a recorder. As previously mentioned, community input from conference participants was used to then revise the papers and to draft the final task force reports. The conference steering committee, in conjunction with the task force groups, compiled the final recommendations between June and December of 1991. However, the major changes or new recommendations garnered as part of this working conference were reported to all participants during the plenary session held at the end of the conference. At that time, participants were invited to comment informally (and formally through the written conference evaluation) on the proceedings. There was one final review of the post-conference revised reports by conference participants in August 1991.

### **Health Promotion Priorities**

As stated earlier, in preparing the discussion papers, the task force groups were limited to ten of the twenty-two topic areas in Healthy People 2000. These topics (listed in Table 1) were selected because they fall within the parameters of the Health Promotion and Tobacco Control Sections and their closely allied programs within the CDHS. The Task Force groups selected those areas which members felt to be highly significant to promoting good health within their respective communities. The details of the selection or priority topic areas are shown in Table 1. The rationale for their selection is contained in the individual task force reports. The four groups viewed the areas differently and some of the groups went on to set priority areas while others did not.

**Table 1**  
**Priority Health Promotion Topic Areas Selected by each Task Force**

	African American	American Indian	Asian/Pacific Islander	Latino
• Physical Activity & Fitness	✓			✓
• Nutrition	✓	✓	✓	✓
• Tobacco	✓		✓	✓
• Violent & Abusive Behavior	✓			✓
• Educational & Community-Based Programs	✓			✓
• Unintentional Injuries				✓
• Heart Disease & Stroke	✓	✓	✓	✓
• Cancer	✓	✓	✓	✓
• Diabetes & Chronic Disabling Conditions	✓	✓	✓	✓
• Surveillance & Data Systems				✓

Source: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. D.H.H.S., 1990. Topic areas in Table 1 are listed in the order in which they appear in Healthy People 2000.

### New/Modified Objectives

Once they had identified priority areas for their respective community, each task force was then asked to review the objectives already developed by the Federal Public Health Service and contained in Healthy People 2000. For the most part, the task force groups accepted Healthy People 2000 as a working document which could be adapted to reflect more accurately the most significant needs of specific populations. During the review of existing information, each Task Force could reject, accept as is, or modify the Healthy People 2000 objectives, or develop new objectives for any topic area. Therefore, the objectives listed in each ethnic Task Force Report represent those objectives which, after a review of existing information, were found to be of importance to meet the health promotion needs for that particular ethnic community.

In preparing the early drafts of the discussion papers, several task force and steering committee members had raised the issue that a number of pressing areas of concern, such as HIV infection, alcohol and drug use, maternal and child health issues, immunizations, and infectious diseases, to ethnic communities were not addressed through the chosen process. These limitations were also noted by some conference participants. As discussed in the "Future Directions" section, the activities being planned by task force groups is to use the initial 10 areas as a starting point and to continue planning for the other 12 health promotion and disease prevention objectives which were not addressed in the initial process.

## **Recommendations for Intervention Strategies**

### **The Process for Developing Recommendations for Intervention Strategies**

A major portion of the Multi-Ethnic Health Promotion Conference was devoted to identifying activities and developing strategies for accomplishing the health promotion objectives. The task force groups had completed their prioritization of topics and had reviewed and quantified ethnic-specific objectives through the various processes described above. The conference participants, who were predominantly community representatives, were asked to review and comment on the work of the task forces. After a review of this information, conference workshop participants were asked to develop three levels of recommendations for each topic area. These levels were:

- Policy
- Resource Development
- Community Intervention

Participants were encouraged by the facilitators of each workshop to gear their recommendations to those activities which can make the greatest improvements in health and which will assist the public, health professionals, and decision makers in both public and private sectors in adopting an agenda for advancing multi-ethnic health promotion.

### **Overall Recommendations**

The following recommendations were developed through several methodologies (e.g., community surveys, literature review, interviews, and the iterative group processes used by facilitators and moderators at the conference). These methods culminated in an extensive listing of recommendations and activities for future action, which were compiled and reviewed separately by each of the four Ethnic Task Force Groups.

The following recommendations are presented from the broadest level of intervention at the policy level to the most focused level of implementation at the community level and represent a distillation of those issues and concepts which cut across diverse program areas and interests. They were formulated in response to the following general perceptions:

- Although there is an overall gap in health status between whites and non-whites in California, a wide range of differences exist across ethnic population subgroups.
- The use of averaged white health data as the normative standard or optimal reference point may not necessarily adequately reflect needs for many ethnic populations:
- Health promotion programs for multi-ethnic populations are characterized by insufficient ongoing funding and inadequate manpower resources at all levels (research, training, community intervention). This, in turn, often results in fragmented services and program activities which cannot comprehensively address individual personal health needs nor adequately address the important social/economic/community antecedents to poor health.
- There is a need for effective culturally and linguistically appropriate health promotion educational materials and methods, as well as trained staff.

Recommendations which target discrete agencies or entities appear within each of the individual Ethnic Task Force Reports. However, overall, the recommendations were made with an understanding that no one agency can or should be responsible for addressing the plethora of health promotion issues brought to light by the task force members and conference participants. Rather, at each level of recommendations being offered, a multitude of agencies will need to be actively involved and partnerships formed to achieve results.

An overriding recommendation made by each Task Force on the final day of the conference was to continue the work of the Steering Committee and the conference. Repeatedly, it was recommended that the conference become an annual event.

### **Summary of Major Policy Recommendations**

1. An Office of Minority Health Affairs should be created within State government, either within the Health and Welfare Agency or the Department of Health Services, to: act as or coordinate the activities of an existing agency acting as a central clearinghouse for health-related information and interventions specific to California's multi-cultural communities; coordinate the activities of multiple state programs; provide technical assistance to communities on program planning, implementation, and evaluation; monitor the progress of State agencies and programs whose activities have an impact on the health of California's ethnic populations; and advocate for necessary resources to address emerging problems.

2. State and federal agencies which routinely collect data or which fund programs which collect data should require the use of ethnic-specific identifying information. Where appropriate, these agencies should make a concerted effort to collect the following:
  - Multiple types of information for specific ethnic subgroups, including non-health information which can contribute to the development of health models for ethnic subgroups.
  - Descriptive epidemiologic data to better understand how and when disease occurs among ethnic groups.
  - Anecdotal information from health and service practitioners on interventions and approaches that are effective.
3. All agencies, organizations, and groups concerned with health promotion and disease prevention should advocate for the creation of a legislative multi-ethnic health promotion agenda in California. This advocacy should emphasize the growing importance of prevention and its integration with other services and such integration should take place at the community, regional, and statewide levels.
4. Health promotion should be emphasized in all programs/program areas funded or implemented by the California Department of Health Services and the California Department of Education. The importance of health promotion should be stressed for all participants in entitlement programs administered by the California Department of Social Services, the California Department of Health Services, and the California Department of Mental Health.

### **Summary of Major Resource Development Recommendations**

1. Institutions of higher education in the health sciences should initiate mandatory cross-cultural, bilingual education and training programs for health and social service providers to increase the number of providers who are able to provide high-quality, appropriate multi-cultural services.
2. All educational institutions and voluntary health agencies in California involved in health professional, patient education, public awareness, and public school education should be encouraged to develop and implement culturally appropriate and relevant health promotion, health protection, and disease prevention curricula, and to implement and promote such education and training programs within their jurisdictions.

3. The California Department of Health Services and local health jurisdictions should actively provide technical assistance to community organizations serving ethnic populations on the availability of funding, grant writing, and community organization/mobilization, effective state-of-the-art education and outreach programs for ethnic populations, and the institutionalization of prevention activities in other existing services.
4. Public-private partnerships should be forged between providers of education and medical services to fund pilot programs which increase access to high-quality, comprehensive chronic disease prevention programs for high-risk ethnic populations.
5. Coverage for health promotion and preventive health services should be increased under existing health care financing and social service programs; targeted tax initiatives and tax incentives should be sought to develop stable, long-term funding for ethnic health promotion programs.

### **Summary of Major Recommendations for Community Intervention**

1. Community health promotion interventions should be comprehensive, well-coordinated, accessible, acceptable, and appropriate for the ethnic population(s) they intend to serve. Programs are more likely to be effective if they build upon existing efforts and expertise, use multiple community channels, and involve community constituency groups in all program phases from community assessment and program planning through implementation and evaluation.
2. Community organizations and groups providing or interested in providing health promotion and disease prevention services should create broad-based support through the creation of public-private partnerships and the development of community coalitions.
3. Broad-based community interventions aimed at long-term change in community norms should use a variety of approaches and have multiple targets, such as:
  - individuals (all age/gender groups)
  - organizational (worksites, churches, schools)
  - environmental (local policies and regulations)
  - education (all levels)
  - community organization (coalitions, consortia)
  - regulatory (federal, state, local)
4. Multi-ethnic health promotion is jeopardized by unstable and decreased resources for programs and trained staff. Federal, state, and local health jurisdictions and voluntary agencies should earmark a portion of their resources/activities for multi-ethnic health promotion; those agencies which make grant funding available should earmark a portion of these funds to address the health promotion needs of ethnic groups.

## Future Directions

### Intent and Distribution of the Task Force Reports

The task force reports provide a framework for efforts to improve health of a large and growing segment of the California population over the present decade. They are intended to serve as a tool for decision makers in public and private agencies in planning and implementing programs. To that end, the conference steering committee has developed a plan for the dissemination of the task force reports. Each conference participant and task force member will receive a copy of each report. The task force groups have developed listings of agencies and individuals who will also receive the Task Force Reports.

To make these reports true working documents, the steering committee has created a list of high and low intensity organizations. The low intensity organizations (e.g., minority organizations, community clinics, community-based organizations) will receive the full set of reports along with the summary information. In addition to this information, the organizations identified as high intensity (e.g., the major voluntary health organizations in California, foundations, hospitals, and health maintenance organizations, professional groups) will receive follow-up contact and technical assistance.

### Building Momentum

As a result of the planning process used in the development of the Task Force Reports, hundreds of community organizations, groups, and individuals have now become familiar with Healthy People 2000 and its objectives for health promotion and disease prevention. Healthy People 2000, along with the Task Force Reports, have become important, highly visible working documents.

To continue the forward momentum, the African American Task Force has already distributed a working paper version of its report and in September and October of 1991 initiated training to its members on ways to present the report and how to provide technical assistance on its use. The conference steering committee, which itself is evolving into an ad hoc advisory body and advocacy group, is reviewing this training format and design for possible use by the other task force groups. As part of its new role and in recognition of the importance of ethnic-specific information in policy formation, the chair and members of the steering committee wrote letters of support for the CDHS' application to the Robert Wood's Foundation to fund an "Information and State Health Policy Program" which at the time of this writing is being considered for funding.

The task force recommendations are now being actively used by programs within the CDHS, academic institutions, and legislative bodies. The CDHS' Health Education-Risk Reduction Program used the task force recommendations in setting priorities for local funding in its Fiscal Year 1992-93 Request for Applications, issued in November 1991. The CDHS' Special Projects Section used information from the initial discussion papers in the development of its funding



proposal to the Centers for Disease Control for a statewide breast and cervical cancer control program for low-income women. This program was funded in July 1991 and is now in operation. The new Breast and Cervical Cancer Program, in turn, initiated a local assistance funding program incorporating many recommendations. The CDHS' Preventive Medical Services' Target Population Committee is currently using the task force reports in the identification of priority areas and strategies for its chronic disease and injury control activities. The CDHS' Tobacco Control Section, which is responsible for implementing Proposition 99, the Tobacco Tax Initiative, has formed four ethnic networks. These networks are also using the recommendations in their planning of future tobacco prevention and cessation programs.

The planning model and the recommendations are also being used to pattern other similar efforts. For example, in November 1991, the Riverside Health Department presented a series of in-service training sessions for its medical and health education staff modelled after the Multi-Ethnic Health Promotion Conference. The California State University at San Francisco has received a health education grant award and in April of 1992 is presenting a "Multi-Cultural Health Challenges" Career Opportunities Workshop. The Steering Committee members, Task Force leadership, and CDHS staff have been invited to participate. It is also the intent of the Steering Committee to advocate that the planning model be utilized by the Department of Health Services in addressing the other twelve health promotion topics of Healthy People 2000 not addressed at the Unity in Health, Diversity in Culture Conference.

Several exciting activities are also happening on the legislative front. On September 27, 1991, Senators Diane Watson, Art Torres, and Lieutenant Governor Leo McCarthy held a forum on Asian/Pacific Islander Health Issues during which the recommendations from the reports were shared. Information and recommendations from the African American Task Force Report were used at the October 11, 1991 meeting of the California Legislature's Subcommittee on Minority Health Affairs, chaired by Assemblyman Curtis Tucker, Jr.

Later that same month, a Steering Committee member, George Flores, M.D., presented information and an overview of lessons learned from the planning process to the California Conference of Local Health Officers at their October 31, 1991 meeting. Finally, information from the reports were presented at a senate hearing on Youth, Health, and Fitness convened on December 2, 1991 by Senator Charles Calderon at California Polytechnic State University in Pomona.

## References

1. U.S. Department of Health and Human Services: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. Government Printing Office, Washington DC., September 1990.
2. Professional Affairs Division, American Public Health Association: Summary of Healthy People 2000: National Health Promotion and Disease Prevention Objectives. (Abridged) American Public Health Association, Washington DC.



**Year 2000**  
**Health Promotion Objectives**  
**and**  
**Recommendations for**  
**American Indians**  
**in California**

# **Year 2000 Health Promotion Objectives and Recommendations for American Indians in California**

## **Summary on the Preparation of the American Indian Task Force Report**

### **Introduction**

The following report represents the efforts of the American Indian (AI) Task Force to assess available information, prioritize health promotion priorities for American Indians, and to develop recommendations for community programs, needed resources, and policy changes. The initial group of topic areas were pre-selected by the California Department of Health Services' (CDHS) Health Promotion Section for discussion at the first Multi-Ethnic Health Promotion Conference held in June 1991 in Sacramento, California.

California has the second largest population of American Indians (between 242,000 and 290,000) of any state, exchanging places with Oklahoma which ranked first in 1990. California's American Indian population is rapidly growing, widely dispersed, and highly mobile. About 70 percent of American Indians are concentrated in the state's major urban areas. However, the remaining 30 percent live on or near 85 reservations and rancherias located in rural areas. Small pockets of Indian communities exist throughout the state which present a challenge to health care access. The tribal composition of California's American Indian population is quite varied and contains both federally recognized and non-recognized tribes. American Indians frequently move from rural areas to the major urban areas and then back, and also relocate to other states. The tribal composition of California's American Indian population is quite varied and contains both federally recognized and non-recognized tribes.

The mobility of the California American Indian population, as well as the diversity of its varied tribal traditions and cultures, influence the prevalence of disease and associated risk factors, access to needed medical services, and the completion of follow-up care. In addition, there are structural differences in clinic services and service deliveries. For example, as a rule, rural reservation clinics are governed by tribal councils, whereas urban clinics are governed by executive directors or multi-tribal boards of directors.

## The Planning Process

The AI Task Force provided the opportunity for tribal governments, health care providers, Indian service agencies, and advocates to participate in the selecting of health promotion priorities. Working from within the Indian community outward in order to motivate the priority-setting process was seen as vital to increase a sense of ownership by community members. The process involved the following seven basic activities:

1. The AI Task Force was established and key information was identified.
2. A survey was developed and distributed throughout the state.
3. Survey responses were collected and summarized.
4. Supplemental research was conducted.
5. A draft discussion paper was developed by the AI Task Force and debated at the conference.
6. Another revised draft was developed and circulated for review during the months following the conference.
7. Final objectives and recommendations were developed and incorporated into the formal AI Task Force Report.

The AI Task Force was established in January 1991. It was composed of representatives from the American Indian community including researchers, academia, health care providers, and tribal leaders. The purpose of the early meetings, which took place in January and February, 1991, were to: 1) review the pre-selected health promotion topic areas for their relevance to health promotion needs of the state's American Indian population and 2) determine a process to gather information and develop recommendations. To accomplish these tasks, the AI Task Force identified key informants, including staff of urban and rural Indian health clinics, various other programs providing health and social services to American Indians, and community leaders such as tribal chairmen.

During the second step, the American Indian Community Survey was developed and sent to 25 Indian health clinics and various organizations and programs. The purpose of the survey was to gather information on health promotion needs of high priority for American Indians. But it also provided information to the community on the planned approach for developing ethnic-specific health promotion objectives for the Year 2000, and invited respondents to attend the conference, where their individual input was welcomed.

After the responses from the survey respondents were collected, the topic areas of high priority were as identified as: heart disease and stroke, cancer, diabetes, and mental health. Other behavioral risk factors identified by respondents include nutrition, tobacco use, and physical fitness. From these areas, four topics in keeping with the conference goals were selected. Once these areas were selected, the AI Task Force conducted background research to collect supportive data and the initial discussion papers were drafted. These were then forwarded back to the key informants for review and presented for further discussion at the conference itself.

Areas of discussion emphasized at the conference included working/networking in the American Indian communities, increasing tribal and urban participation, and setting priorities for future health promotion intervention. To ensure agreement on their content and measurable objectives, the papers were revised again after the conference and forwarded to key informants and conference participants prior to their finalization in November 1991.

## **Findings of the American Indian Task Force**

### Heart Disease

Heart disease was selected as the most important area of focus by the AI Task Force for two reasons: it continues to be the number one cause of death among American Indians, and American Indians have high prevalence of multiple risk factors for heart disease, namely tobacco use, elevated serum cholesterol, high blood pressure, and physical inactivity. In addition to accepting 14 objectives from Healthy People 2000, which address cardiovascular disease mortality and the prevalence of associated risk factors, the AI Task Force placed greater emphasis on the proportion of American Indians (80 percent) who should be aware of their high blood cholesterol.

### Cancer

The AI Task Force developed 16 objectives for cancer which are specific to the American Indian population. For the most part, these objectives are in accordance with the national objectives listed in Healthy People 2000. However, the AI Task Force revised one risk reduction objective to delete specific amounts of daily consumption of complex carbohydrates, grains, and fresh fruits and vegetables. Four new objectives were added as the Services and Protection Objectives. These address multiple needs within the American Indian community for: 1) improved tracking systems for American Indians with diagnosed cancers; 2) cancer registries which list ethnicity; 3) women's health specialists to provide early detection and follow-up services; and 4) the need high-quality, low-cost services in isolated rural areas to provide regionalized care.

### Diabetes

The AI Task Force developed four objectives for diabetes, one of which has multiple components, and all of which incorporate new ethnic-specific information. Three objectives address diabetes-related deaths, incidence of diabetes, and severe complication from diabetes. The final objective addresses the need to increase to at least 75 percent, the proportion of American Indians with diabetes who receive formal patient education about community and self-help resources as an integral part of their care.

## Nutrition

The AI Task Force found that issues related to nutrition and food consumption among American Indians involve complex interactions between social, cultural, economic and physiological factors and, further, that just as diet contributes to the development of multiple chronic diseases (coronary heart disease, cancer, diabetes) and conditions (obesity, tooth decay, anemia) among this ethnic group, with improvements, so can it contribute to their prevention.

Using ethnic-specific data, the AI Task Force created three Health Status Objectives for coronary heart disease, cancer, and diabetes-related mortality. Twelve Risk Reduction Objectives were developed to address diet and, to a lesser degree, physical activity. Although the objectives are ethnic-specific, most are in accordance with the objectives listed in Healthy People 2000. One exception, however, is that the AI Task Force felt that a higher proportion (75 percent) of overweight American Indian adolescents and adults should adopt sound dietary practices and physical activity to attain an appropriate body weight.

Finally, the Task Force modified four of the Services and Protection Objectives relating to nutrition labelling, low-calorie food choices in restaurants, institutions, and schools (K-12) to reflect their lesser importance as sources of information for this group. A fifth objective was created which addresses the need for increased availability of high-quality food resources, such as school lunch programs, Women, Infant, and Children (WIC) Supplemental Food Program, and gardening programs.

## **Major Recommendations**

The overall recommendations formulated by the AI Task Force concerned the need for new policies which would direct increased funding for community service and research programs for the state's American Indian population. The need for policies favoring the collection of ethnic-specific data was also noted, as was the need for additional resources with which to support targeted culturally appropriate community-based programs and services. Recommendations for community programs focused upon ways to increase the use of preventive resources, address system barriers, such as lengthy delays in clinics serving Indians, and improve follow-up services as a critical component of comprehensive primary and secondary preventive measures.

## **American Indian Task Force**

Felicia Hodge\*  
David Whitehorse\*  
Arica Williams\*  
Trula Breuninger  
Olivia Forest-Davis  
Jenny Joe  
A. Jean Pickus  
Melody Williams

*Staff Support:*  
Vicci Schlegel  
Janet Wetta  
California Department of Health Services

\* Steering Committee Members





# Cancer

## Cancer\*

### Abstract

Cancer-related deaths are the third leading cause of death among American Indians. For those over the age of 45 years, cancer is the second leading cause of death. Although the incidence rates for most cancers are equal to or lower than the general population, what is alarming is the low cancer survival rates. The Federal Indian Health Service reports that the most common sites of cancer among American Indian males are: lung, 18 percent; prostate, 17 percent; colorectal, 12 percent; kidney, 6 percent; and stomach, 6 percent. For American Indian females, the most common sites are breast, 18 percent; cervix, 13 percent; colorectal, 12 percent; and lung, 9 percent. The American Indian five-year survival rate for all cancers is the lowest recorded for all ethnic groups. The American Indian Task Force established 16 objectives and made 15 recommendations for cancer control. These address multiple needs within the American Indian population for improved ethnic-specific data and culturally appropriate low-cost tracking, early detection, and educational services.

### Rationale

American Indians have unique patterns of cancer morbidity and mortality. Breast and cervical cancer are significant cancers in American Indian women due to their high mortality and low survival rate as compared to other ethnic/cultural groups. The incidence of breast cancer among American Indians has been estimated from five studies to be from 33 percent to 70 percent lower than the rate for the general U.S. population. However, American Indian women with breast cancer are diagnosed at a more advanced stage of disease and, therefore, stage-specific survival is poorer than for non-Indian women. Five-year survival rates are reported to be 49.6 among Indians as compared to 73.1 for whites.

National data indicate that American Indian women have one of the highest rate of cervical cancer incidence of any ethnic group studied: 22.6 cases per 100,000 populations as compared to 20.2 for blacks and 8.8 for whites. The mortality rate from cervical cancer is 5.8 deaths/100,000 for Indians compared to 3.2 for whites. At 65 percent, the five-year relative survival rate for cervical cancer is extremely poor compared to non-Indians. This is attributed, in part, to inadequate screening and follow-up care.

Cancer is a relatively "new" illness among the American Indian population. As recently as fifty years ago, Indian mortality was caused by acute illnesses such as tuberculosis, measles, and smallpox. Today, Indians are dying from chronic health problems including cancer, heart disease, and diabetes. As a "new" illness, cancer has only recently received recognition as a

\* Corresponds to Topic Area 16 of Healthy People 2000 National Health Promotion and Disease Prevention Objectives, DHHS, 1990.

health problem requiring investigation among American Indians. Little or no research has been conducted regarding the knowledge, behaviors, or practices related to cancer among this population. Little is known about the role culture plays in creating barriers which impede cancer screening.

The less frequent use of preventive measures by American Indians is indicative of cultural and socio-economic barriers in need of special attention. Barriers to prevention, screening, and follow-up care are thought to include differences in illness beliefs, education, concept of disease, communication styles, and fear of cancer treatment and its consequences. At-risk American Indians often need to cope with economic poverty, substandard housing, and high unemployment. Thus, preventive health care may be a lower priority in relation to life's other demands.

System barriers also contribute to the problem of inadequate follow-up care. Lengthy delays between the screening and referrals for follow-up contribute to noncompliance. It has been reported by a California urban Indian clinic that referral appointments for abnormal Papanicolaou (PAP) smears can take up to eight months. The system often does not pick up abnormal Pap smears because of high patient volume, inadequate funding, and lack of a tracking system. Cultural differences between provider and patient also contribute to communication problems. Higher cancer mortality among the American Indian population requires attention to increased screening and follow-up care. Barriers to accessing appropriate care must be addressed in the community and health care system.

Another significant problem in California is the lack of adequate cancer registry data which is specific to American Indians. Cancer registries in California need to specify race, especially American Indian/Alaska Natives, so that data can be useful for the state's less populous minority groups.

### **Health Status Objectives**

1. Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 in the American Indian population.
2. Slow the rise in lung cancer deaths to achieve a rate of more than 42 per 100,000 in the American Indian population.
3. Reduce breast cancer deaths to more than 20.6 per 100,000 Indian women.
4. Reduce uterine cervix cancer deaths to more than 1.3 per 100,000 Indian women.
5. Reduce colorectal cancer deaths to more than 13.2 per 100,000 in the American Indian population.

## Risk Reduction Objectives

1. Reduce dietary fat intake to an average of 30 percent of calories or less and reduce the average saturated fat intake to less than 10 percent of calories among American Indian children, adolescents, and adults.
2. Increase complex carbohydrates, grains, and fresh fruits and vegetables consumption of American Indian youth and adults.
3. Increase to at least 75 percent the proportion of primary care providers who routinely counsel American Indian patients about tobacco use cessation, diet modification, and cancer screening recommendations.
4. Increase to at least 80 percent the proportion of Indian women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the last one to two years.
5. Increase to at least 95 percent the proportion of Indian women aged 18 and older with uterine cervix who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding one to three years.
6. Increase to at least 50 percent the proportion of American Indians aged 50 and older who have received fecal occult blood testing within the preceding 1 to 2 years, and to at least 40 percent those who have ever received proctosigmoidoscopy.
7. Increase to at least 40 percent the proportion of American Indians aged 50 and older visiting a primary care provider in the preceding year who have received oral, skin, and digital rectal examinations during one such visit.
8. Require the cancer registries in California to identify American Indians as a part of their race identification.
9. Develop a tracking system for persons diagnosed with cancer. Cancer registries and other agencies (American Cancer Society) need to list ethnicity or race of clients.
10. Develop a center of women health specialists specifically designed as a women's clinic providing screening services such as Pap smears, etc.
11. Increase the number of mammography machines designated for the isolated rural areas, i.e., an Indian project could have one machine for an entire region and/or a mobile unit for outlying areas.

## Recommendations:

### Community Intervention

- Increase awareness among American Indian men about their risk for colon and rectal cancer (most common in men over 40), cancer of the testicles (most common in men 15-35), prostate cancer (most common in men 60-90), and bladder cancer (most common in men aged 60-90). Also increase cancer screening and self-exam techniques.
- Increase awareness among American Indian women about their risk for breast and cervical cancer. Increase Pap smear testing, colposcopy training, self-breast exam training, mammography, and colorectal screening.
- Indian women should be taught the proper technique for breast self-exam and be advised about the importance of yearly clinical examinations including breast exam palpation and cervical examinations as recommended. Mammography should be available and become a routine part of disease prevention services in the American Indian population.
- The utilization of cancer screening by Indians must be improved by increasing patient education, prevention, and screening in a culturally sensitive manner.
- Increase follow-up care on all abnormal screenings and on clients identified to be at high risk in the American Indian population. Ensure that all eligible clients receive screenings at appropriate recommended intervals.
- Improve and/or computerize tracking of preventive health care services such as Pap smears, mammography, etc.
- Add ethnic/racial identification of American Indian to the California Cancer Registry's data collection and surveillance system.
- Develop better tracking of American Indians diagnosed with cancer and precancerous conditions. Work with the Federal Indian Health Service and other state and local Indian programs to develop a statewide computerized system.
- Increase awareness of adequate consumption of complex carbohydrates and fiber (grains, fruits, vegetables) and decrease the consumption of fat associated with low rates of some types of cancer.

## **Policy**

- Increase awareness of the cancer risks among American Indians, including community leaders and policy makers in order to initiate supportive legislation, resource allocation, and program development.
- Support and fund research projects targeting intervention and educational development to reduce cancer incidence and cancer mortality.

## **Resource Development**

- Improve epidemiologic descriptions of the cancer risks among American Indians in California and transmit new information through channels (health care providers, researchers, and Indian leaders) to promote disease prevention treatment.
- Develop cultural-specific educational materials (urban and rural) targeted to high-risk factors, especially lifestyle and environmental factors.
- Encourage or help develop a cadre of Women and Men Health Specialist to provide gender-specific clinic services and peer counseling.
- Increase the number of disease prevention/health promotion programs addressing the contributions of diet to cancer prevention.

# Diabetes

## Diabetes\*

### Abstract

Diabetes is a significant and widespread problem among American Indians. Since the 1960s, the Indian death rate related to diabetes has been reported to be more than twice of the general population of the United States. The Federal Indian Health Service reports that the 1987 age-adjusted diabetes mortality rate in nine regional areas was 35.8 deaths/100,000, which is 265 percent higher than the U.S. All Races rate of 9.8 deaths/100,000. Diabetes is currently documented to be the second leading cause of adult outpatient visits in the Indian Health Service. In some Southwest tribes, 50 percent of all adults are reported to have diabetes--the highest prevalence of diabetes in the world. The AI Task Force established four objectives (one with five subobjectives) and made nine recommendations for diabetes control. These address the need for improved ethnic-specific data, increased public and health professional awareness of the problems posed by diabetes among American Indians, and culturally specific community-based and self-help programs.

### Rationale

Diabetes mellitus is a serious, chronic disease which impairs the body's ability to metabolize carbohydrates, proteins, and fats. Individuals with Type 1 diabetes or insulin-dependent diabetes mellitus (IDDM), previously called juvenile onset diabetes, lack the ability to normally produce insulin. Daily administration and monitoring of insulin is mandatory. Diabetics with IDDM tend to be younger than 40 years of age at onset, although IDDM can occur at any age. Type II diabetes (noninsulin-dependent diabetes mellitus-NIDDM), often called adult onset diabetes, is the more common type of diabetes. It is frequently related to patient weight and is more often seen in those individuals who are obese. In NIDDM, some insulin is produced by the pancreas, but the insulin is not effectively used. NIDDM diabetics tend to be older (typically over 40 years of age). And although insulin is sometimes given in order to lower blood sugar levels, dietary counseling, development of sound eating habits, and exercise are essential to control the disease. Although treatment with insulin, other medications, diet, and exercise have extended the average life expectancy of diabetics, there is still no known cure for the disease.

Other types of diabetes include gestational diabetes mellitus (GDM) and impaired glucose tolerance (IGT). A temporary metabolic imbalance in pregnant women often leads to gestational diabetes. Proper diagnosis and treatment is essential because of the increased risk of perinatal morbidity and mortality as well as risk to the unborn fetus. Also, women who get GDM are at

\* Corresponds to Topic Area 17 of Healthy People 2000: National Health Promotion and Disease Prevention Objectives, DHHS, 1990.



higher risk of developing diabetes in the future. Impaired Glucose Tolerance is often called borderline diabetes because it occurs when the fasting plasma glucose level is between normal and diabetic levels. Although persons with IGT may have no symptoms of diabetes, IGT can be managed with diet and weight loss to prevent the further onset of diabetes.

Patient failure to fully follow their prescribed treatment regimen is a serious and widespread occurrence in the American Indian population. Reports estimate that from 50 to 75 percent of diabetics are noncompliant as defined as failure to fully follow treatment recommendations (monitoring/diet/medication). Untreated diabetes can lead to complications such as infections, periodontal disease, gangrene, coma, and death. Chronic complications can also affect pregnant women and the developing fetus. Disabilities directly related to diabetes include blindness (retinopathy), kidney disease/failure (nephropathy), amputations, and other vascular-related conditions such as strokes and heart attacks.

Diabetic patients, especially American Indian patients, tend to have multiple problems and require multiple referrals to other services. Access to health care and continuity of care is hindered in the Indian population by high mobility, gaps in health care, and unavailability of resources or lack of knowledge of available resources. The keystones to the prevention of diabetes complications are patient education and appropriate monitoring and compliance with treatment regimens. Increasing patient responsibility for the maintenance of their health will save lives, limbs, and dollars.

Diabetes is a highly treatable disease. Risk factors include obesity, poor nutrition, and noncompliance with treatment regimens--each of which is potentially amendable to intervention. Effective strategies for improving the diabetes problem among American Indians include widespread screening, patient education, and treatment.

### **Health Status Objectives**

1. Reduce diabetes-related deaths in the American Indian population to no more than 48 per 100,000.
2. Reduce the more severe complications of diabetes as follows:
  - 2.a Reduce end-state renal disease to 1.9 per 1,000.
  - 2.b Reduce blindness to 1.4 per 1,000.
  - 2.c Reduce lower extremity amputation to 4.9 per 1,000.
  - 2.d Reduce perinatal mortality to 2 percent.
  - 2.e Reduce major congenital malformations to 4 percent.
3. Reduce diabetes to an incidence of no more than 2.5 per 1,000 people and a prevalence of no more than 62 per 1,000 people.

## **Services and Protection Objectives**

1. Increase to at least 75 percent the proportion of American Indians with diabetes who receive formal patient education including information about community and self-help resources as an integral part of the management of their condition.

## **Recommendations:**

### **Community Intervention**

- Increase awareness of diabetes, its complications, and advances in diabetes care among American Indians and health care providers.
- Develop programs to prevent obesity among Indian youth with particular focus on exercise and diet.
- Develop community exercise programs in both rural and urban Indian communities.
- Develop community programs to modify activity levels and eating habits.
- Develop camps (for teaching nutrition and exercise) for children from high -risk families.

### **Policy**

- Improve the care of American Indians with diabetes by developing and efficiently utilizing available resources, improving distribution and delivery of diabetes health care services, promoting culturally appropriate techniques which foster patient compliance, and effectively implementing prevention methodologies.
- Increase awareness of the diabetes problem among American Indians, including community leaders and policy makers, in order to initiate supportive legislation, resource allocation, and program development for the control of diabetes mellitus.

### **Resource Development**

- Improve epidemiologic descriptions of the diabetes problem among American Indians in rural and urban areas of California and transmit new information through appropriate channels to promote disease prevention and improve treatment and compliance.
- Develop culturally specific self-help groups/programs to empower individuals to become responsible for their own health.

# **Heart Disease and Stroke**

## Heart Disease and Stroke\*

### Abstract

Cardiovascular disease is currently the number one cause of death among American Indians. Although this is not surprising (considering that heart disease and strokes are the leading cause of death among the general population), what is disturbing is the fact that several of the risk factors associated with heart disease and strokes are highly preventable in the American Indian population. Cigarette smoking, high cholesterol levels, high blood pressure, and lack of physical exercise are all major contributors to heart disease, strokes, and preventable death and disabling. To address these problems, the American Indian Task Force established 14 objectives and made 11 recommendations which emphasize the importance of reducing behavioral risk factors for cardiovascular disease through community programs, interventions at cultural events, and expanded use of referral and support systems.

### Rationale

The American Indian experience with regard to the above risk factors are alarming. For example, a recent analysis of death certificates in the State of California indicates that American Indian smoking attributable mortalities are more than twice that of the general population. During the three-year period of 1986-88, the smoking attributable death for Indian males was 37.4 percent, more than twice that experienced by the general male population (17.8 percent). For Indian females, the picture is even more disturbing. The California female smoking attributable mortality for All Races was 12.4 percent. At 41.7 percent, the American Indian female experience was more than three times that of the non-Indian female.

High cholesterol levels, high blood pressure, and lack of physical exercise all lead to the risk of heart disease and strokes in the American Indian population. Given the life expectancy of American Indians is at least 4 years below that of the general population, reducing associated risk factors is a priority.

Adopting a more healthy lifestyle through changing individual behaviors will reduce the risk of heart disease in the American Indian population. Prevention must begin with the individual to encourage change. In addition, primary care providers in Indian communities should initiate the adoption of healthier lifestyles by recommending diet, and if necessary, drug therapy to control high blood pressure and blood cholesterol levels. Patient education and screening should also be encouraged at Indian clinics and at other Indian functions/agencies.

\* Corresponds to Topic Area 15 of Healthy People 2000: National Health Promotion and Disease Prevention Objectives, DHHS, 1990.

### **Health Status Objectives**

1. Reduce coronary heart disease deaths to no more than 100 per 100,000 American Indian population.
2. Reduce stroke deaths to no more than 20 per 100,000 American Indian population.
3. Slow the rise of deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 25 deaths per 100,000 American Indians.

### **Risk Reduction Objectives**

1. Increase to at least 50 percent the proportion of American Indians with high blood pressure whose blood pressure is under control.
2. Increase to at least 90 percent the proportion of American Indians with high blood pressure who are taking action to help control their blood pressure.
3. Increase to at least 80 percent the proportion of Indian adults with high blood cholesterol who are aware of their condition.
4. Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL.
5. Increase to at least 80 percent the proportion of American Indians taking action to reduce their blood cholesterol to recommended levels.
6. Reduce cigarette smoking to a prevalence of no more than 20 percent among American Indians aged 20 and older.
7. Reduce the initiation of cigarette smoking or chewing tobacco by American Indian children and youth so that no more than 15 percent have become regular cigarette smokers by age 20 and none become chewers.

### **Services and Protection Objectives**

1. Increase to at least 90 percent the proportion of Indian adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was within normal or high range.
2. Increase to at least 75 percent the proportion of Indian adults who have had their blood cholesterol checked within the preceding 5 years.

3. Increase to at least 75 percent the proportion of primary care providers who initiate diet and, if necessary, drug therapy at levels of blood cholesterol consistent with current management guidelines for patients with high blood cholesterol.
4. Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer high blood pressure and/or cholesterol education and control activities to their employees.

## **Recommendations:**

### **Community Intervention**

- Increase cholesterol and blood pressure screening at tribal meetings, Pow-Wows, and other community events.
- Screen and monitor children who have a family history of heart disease and high cholesterol.
- Fund clinics to implement a weight management program and develop educational materials that address the connection between obesity and health disease.

### **Policy**

- Direct funding to tribes and urban sites to start programs to increase physical exercise, increase nutritionally balanced dietary intake, decrease smoking, and lower blood pressure among tribal members.
- Direct funding to research projects targeting intervention and educational development to reduce health disease among American Indians.
- Direct funding to tribes and urban sites for programs to encourage adult smokers/chewers to quit through culturally appropriate educational programs and support groups.

### **Resource Development**

- Develop culturally appropriate smokeless tobacco/smoking cessation and prevention programs for children and youth.
- Develop strategies to reduce dietary risk factors for heart disease by encouraging the active support and participation of the media, medical profession, food industry, nutritionists, public health personnel, educators, and government.

- Develop educational materials for professionals on culture and “obesity” to promote sensitivity and appropriate response of non-Indian medical providers to “obese” Indians.
- Develop low fat, low sodium meals/recipes with government-issued foods.
- Develop referral systems of support groups for those diagnosed with heart disease.





# Nutrition

## Nutrition\*

### Abstract

Issues related to nutrition and food consumption involve complex interactions among social, cultural, economic and physiological factors. Adequate intake of essential nutrients and energy sources are necessary for satisfactory rates of growth and development, physical activity, reproduction, lactation, recovery from illness or injury, and maintenance of health throughout the life cycle. Deficits of essential nutrients or energy sources can lead to several specific diseases or disabilities and increase susceptibility to others. Excessive or inappropriate consumption of some nutrients may contribute to adverse conditions, such as obesity, or may increase the risk for certain diseases (e.g., heart disease, diabetes mellitus, high blood pressure, dental caries, and some types of cancer). While the role of nutrients in these diseases has not been definitely established, epidemiological and laboratory studies offer important insights which may help people in making food choices to enhance their prospects of maintaining good health. The American Indian Task Force established 17 objectives to reduce deaths from coronary heart disease, cancer, and diabetes through dietary and physical activity intervention. Ten recommendations were developed to address the need for more comprehensive, high-quality, low-cost nutrition education and service programs.

### Rationale

Diet contributes in substantial ways to the development of chronic diseases and modification of diet can contribute to their prevention. The magnitude of the health and economic cost of diet-related disease suggests the importance of dietary changes. The health implications include the following:

1. High intake of total dietary fat is associated with increased risk for obesity, heart disease, some types of cancer, and possible gallbladder disease. Dietary fat contributes more than twice as many calories as equal quantities (by weight) of either protein or carbohydrates. Some studies indicate that diets high in total fat are associated with higher obesity rates.
2. Obesity increases the risk for diabetes, high blood pressure and stroke. In addition, it appears to be an independent risk factor for coronary heart disease. Studies have shown consistently that overall risk for death is increased with excess weight and that the risk increases as severity of obesity increases.
3. Dietary patterns emphasizing foods high in complex carbohydrates and fiber are associated with lower rates of diverticulosis and some types of cancer.

\* Corresponds to Topic Area 2 of Healthy People 2000: National Health Promotion and Disease Prevention Objectives, DHHS, 1990.

4. Studies indicate a relationship between a high sodium intake and the occurrence of high blood pressure and stroke.
5. Although genetic, behavioral, and other dietary factors also influence dental health, the major role of sugars in promotion of tooth decay is well established from studies. 6. Inadequate dietary calcium consumption in the first three to four decades of life may be associated with increased risk for osteoporosis, especially for women.
6. Inadequate dietary calcium consumption in the first three to four decades of life may be associated with increased risk for osteoporosis, especially for women.
7. Dietary iron deficiency is responsible for the most prevalent form of anemia.
8. Breast fed infants appear to enjoy significant health advantages when compared with infants fed with breast milk substitutes. In particular, the immunologic characteristics of breast milk may increase resistance to infections and perhaps certain allergies.

There are health consequences to the unhealthy dietary practices. In 1985-87, “diseases of the heart” and malignant neoplasms accounted for 27.4 and 14.6 percent, respectively, of all deaths among American Indians in California. In 1987, the age-adjusted diabetes mellitus mortality rate for the Indian Health Service (IHS) California Area population was 20.8 deaths per 100,000 population. This is higher than the U.S. rate of 9.8 deaths. That same year, the age-adjusted mortality rate from “diseases of the heart” for the IHS California Area population was 105.3 per 100,000. Because there is an underreporting of Indian race on State death certificates in California, these mortality data are suspect and, therefore, should be interpreted with caution.

### Health Status Objectives

1. Reduce coronary heart disease deaths to no more than 100 per 100,000 in the American Indian population in California.  
(Age-adjusted baseline: 105.3 per 100,000 in 1987.)
2. Reverse the rise in cancer deaths to achieve a rate of no more than 50 per 100,000 in the American Indian population in California.  
(Age-adjusted baseline: 55.5 per 100,000 in 1987.)
3. Reduce diabetes-related deaths to no more than 20 per 100,000 in the American Indian population in California.  
(Age adjusted baseline: 20.8 per 100,000 in 1987.)

## **Risk Reduction Objectives**

1. Reduce dietary fat intake to an average of 30 percent of calories or less and reduce the average saturated fat intake to less than 10 percent of calories among American Indian children (2 and older), adolescents (aged 12-19), and adults.  
(Baseline: no data available specific to American Indians in California.)
2. Increase complex carbohydrates, grains, and fresh fruit and vegetables in the diets of American Indian adults and youth.  
(Baseline: No data available specific to American Indians in California.)
3. Reduce overweight (overweight is defined as body mass index or BMI exceeding the 85 percentile) to a prevalence of no more than 20 percent among American Indians aged 20 and older and no more than 15 percent among adolescents aged 12 through 19.  
(Baseline: no data available specific to American Indians in California.)
4. Increase to at least 75 percent of the proportion of overweight American Indians aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight.  
(Baseline: no data available.)
5. Reduce iron deficiency to less than 5 percent among American Indian children aged 1 through 4 and among American Indian women of childbearing age.  
(Baseline: no data available.)
6. Obtain adequate data on the nutritional status of American Indians in urban and rural areas of California.
7. Obtain or initiate data on obesity or level of obesity and percent body fat among American Indians in urban and rural areas of California.
8. Ensure calcium intake so at least 50 percent of youth aged 12 through 24 and 50 percent of American Indians pregnant and lactating women consume three or more servings daily of foods rich in calcium.  
(Baseline: no data available.)

9. Ensure salt and sodium intake so at least 50 percent of American Indian homes prepare foods without adding salt, at least 60 percent avoid using salt at the table, and at least 30 percent of American Indian adults regularly purchase foods modified or lower in sodium.

(Baseline: no data available. Percentage decreased from Objective 2.9 as stated in Healthy People 2000.)

10. Increase to at least 65 percent the proportion of American Indian parents and caregivers who use feeding practices that prevent baby bottle tooth decay.

(Baseline: no data available.)

11. Increase to at least 75 percent the proportion of American Indian mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old.

(Baseline: 47 percent of American Indians breastfeed their babies.)

12. Increase to at least 85 percent the proportion of people aged 18 and older who use food labels to make nutritious food selections.

(Baseline: no data available.)

## Service and Protection Objectives

1. Achieve useful and informative nutrition labeling for virtually all processed foods.

(Baseline: 60 percent of sales of processed foods regulated by Food and Drug Administration had nutrition labeling in 1988.)

2. Increase to at least 80 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices.

(Baseline: no data available.)

3. Increase to at least 80 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutrition principles in the 1990 Dietary Guidelines for Americans.

(Baseline: no data available.)

4. Increase to at least 75 percent the proportion of the schools that provide nutrition education from preschool through 12th grade, preferably as part of quality school health education.

(Baseline: no data available.)

5. Increase the availability of food resources, such as school lunches, Women, Infant, and Children (WIC) Food Supplement programs, and gardening programs.

## **Recommendations:**

### **Community Intervention and Policy**

- Direct funding to programs to educate the American Indian public about the dietary choices most conducive to prevention and control of certain chronic diseases. Educational efforts should begin in primary school and continue throughout the secondary grades and later life. The importance of adequate physical activity should also be stressed.
- Improve food labeling that will offer opportunities to inform people about the nutrient content of foods so as to facilitate dietary choices most conducive to good health.
- At Indian elderly feeding sites, provide low salt, low cholesterol and low calories meals.
- Fund demonstration projects that utilize traditional native foods.
- Provide food preparation demonstrations.
- Encourage Indian Health Service clinics and Indian health programs to co-sponsor health promotion activities (weight loss competitions, cook-offs, supermarket tours, etc.), and use incentives (t-shirts, prizes, etc.) to encourage participation of tribal and urban Indian organizations.
- Develop health and nutrition status baseline data specifically for American Indians in rural and urban areas of California.

### **Resource Development**

- Indian health clinics should have Registered Dietitians/Nutritionists on staff to provide health care programs for individuals of all ages. Programs should include nutrition counseling for individuals or groups, interpretation and implementation of prescribed therapeutic diets tailored to individual food and lifestyle preferences, referral to appropriate community services and food assistance programs, monitoring of progress, and appropriate follow-up.
- Create an Indian cookbook or video to include traditional Indian recipes as well as modern non-traditional recipes modified to reduce the amounts of fat, sodium, and sugar.
- Develop culturally appropriate nutritional educational materials.



The front cover graphic was designed by Joan Tarika Lewis of Oakland, CA. Ms. Lewis strived to illustrate unity with her circular design of symbols from different cultures. She was impressed by the similarity between the symbols and how well they blend into one another. She commented,  
*"We are all closer to one another than we think."*

